EXHIBIT 1620-2

ALTCS MEMBER CHANGE REPORT

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Date ___/___/___	ALTCS Program Contractor:	Reported By:	Phone #:

Member Name:	AHCCCS ID:	
Sent To: ❑ ALTCS Local Office ❑ DHCM ❑ Medical QC Supervisor	DOB:	Customer #:

Verification Attached? ❑ YES ❑ NO Verification Type: ❑ DE-130 ❑ Case Notes ❑ Other: _____

PART I - Demographic/Miscellaneous (Send DE-701 to ALTCS local office)

❑ **Address Change:**
- ❑ Residential
- ❑ Mailing
- ❑ Move to Home in Different Fiscal County
- ❑ Move Out of State

For: ❑ Representative ❑ Member

Effective Date: ___/___/___

❑ Name ❑ Sex ❑ DOB
❑ Phone # ❑ SSN ❑ DOD ❑ Other:

Explain Change:

PART II - Placement/Living Arrangement (Send DE-701 to ALTCS local office)

FROM: (previous residence) Enter facility name (if applicable), address and phone number. **TO:** (new residence) Check living arrangement. (Abbreviations in parentheses are used by the ALTCS local offices). Effective date: Indicate effective date of change. Length of Stay: Indicate length of stay and if temporary, enter date. Facility Status: Check facility Status (if applicable). Enter facility name (if applicable), address, phone number. Enter comments.

FROM:		Phone: ( )	
Address:	City:	State:	Zip Code:

TO: Living Arrangement
- ❑ NF/ICF-MR
- ❑ Home
- ❑ Adult Foster Care Home *****
- ❑ Assisted Living Home *****
- ❑ Assisted Living Center *
- ❑ Assisted Living Center Room
- ❑ Level I or II Behavioral Health Center
- ❑ Level III Behavioral Health Center
- ❑ DD Group Home/Adult Development Home
- ❑ Child Developmental Foster Home/Large Group Setting
- ❑ Alternative Acute Living Arrangement
- ❑ Other _____

Effective Date: ___/___/___

Length of Stay:
- ❑ Permanent
- ❑ Temporary Until: ___/___/___
- ❑ Unknown

Facility Status:
- ❑ Medicare Certified
- ❑ Not Medicare Certified
- ❑ Licensed
- ❑ Unlicensed
- ❑ Contracted with PC
- ❑ Not Contracted with PC

Note to Local Office:

To change from Acute to LTC call the Technical Service Center in addition to entering the change in ACE.

***** If not registered with AHCCCS or licensed by ADHS or OBHL, use Alternative Acute Living Arrangement.

Facility Name:	Provider ID:	Phone: ( )	
Address:	City:	State:	Zip Code:

Comments:

DE-701 (Rev. 10/07, 7/04)

Member Name:	AHCCCS ID:

PART III - Client Status

Send the DE-701 to the ALTCS local office to report the following changes:		
❑ Member requests voluntary withdrawal from ALTCS (DE-130 attached) ❑ Change Contract Type from LTC to Acute for retroactive period (refusing services) ❑ Temporarily Absent from Arizona ❑ Returned to Arizona ❑ Tribal Enrollment Change – DHCM was contacted ❑ On-Reservation ❑ Off-Reservation	Date From: __/__/__	Comments:
Send the DE-701 to DHCM for the following changes:		
❑ From LTC to Acute– (Attach case notes) ❑ Services not available ❑ Temporarily out of service area ❑ Refusing Services (DE-130 not signed) ❑ From Acute to LTC ❑ Services are available ❑ No longer out of service area ❑ No longer Refusing Services	Date To: __/__/__	

PART IV - Change PC Within Maricopa County (Send DE-701 to ALTCS local office)

❑ Member Requests Enrollment Change to: _____(Program Contractor)

Reason:

❑ Erroneous Information/Error ❑ Family Continuity ❑ Lack of Choice ❑ Continuity of Placement

Comments:

PART V - Medicare/Other Health Insurance (Send DE-701 to ALTCS local office)

Medicare Part A ❑ YES ❑ NO Effective Date: __/__/__

Medicare Part B ❑ YES ❑ NO Effective Date: __/__/__ Disenrollment Date: __/__/__ Medicare Number: _____

Other Insurance ❑ YES ❑ NO Effective Date: __/__/__ Policy Number: _____

Insurance Carrier:

PART VI - Share of Cost (Send DE-701 to ALTCS local office)

❑ Reduce Share of Cost Due to Death of Member ❑ Other (Specify):	Effective: Month/Year __/__

PART VII - Income/Resource Change (Send DE-701 to ALTCS local office)

❑ Income ❑ Resources Explain the change:

Source or Type: _____

PART VIII - Ventilator Status Change/PAS Reassessment Request (See form instructions)

❑ Ventilator Dependent ❑ Non-Ventilator Dependent Effective date: _____

❑ PAS Reassessment Request – Check Reason for Assessment and provide comment

❑ Improvement in functional abilities or medical condition to the extent that the member may no longer be medically eligible. Explain the change in comments.

❑ Transitional member now in NF; expected to exceed 90 days: (Complete Part II)

❑ Other (Explain):

Comments:

RESPONSE - (Completed by AHCCCS Employee)

❑ Refer to Part(s) _____

❑ Change Completed
Date Completed __/__/__
Effective Date __/__/__
❑ Member no longer eligible
Effective Date __/__/__

❑ Failed PAS
❑ Other Reason _____

❑ Member still eligible
❑ Passed PAS Reassessment
❑ DHCM has determined LTC status should continue

❑ Contract Type Change from _____ to _____
Begin date _____ End date _____
❑ SOC increased to $ _____ Effective Date: __/__/__
❑ SOC decreased to $ _____ Effective Date: __/__/__
❑ Income Changed
❑ Resources Changed

❑ Member eligible for acute care only
Effective Date __/__/__
❑ ALTCS Acute care
❑ Health Plan _____

❑ No Action Taken (see comments)

Comments:

Signature of AHCCCS Staff Person _____ Date Returned __/__/__

EXHIBIT 1620-2 (CONTINUED)
GUIDELINES ON WHEN TO USE A MEMBER CHANGE REPORT FORM

A Member Change Report (MCR) form should be sent to the local ALTCS eligibility office (except where noted) to report or request the following:

- To report a change in the member's demographic data (for example, address, marital status, name change, etc.).
- To report a change in the member's financial status (or that of his/her household) which may affect their ALTCS eligibility, including the initiation of the member's spouse as the paid caregiver.
- To report a change in an ALTCS member's placement.
- To report a change in the contract or certification status of the facility where a member resides if the member chooses to remain in the facility.
- To report a change in the member's Ventilator Dependent status and request a PAS reassessment.
- To report a change in the member's DD status and request a PAS reassessment.
- To report he closure of a member's service plan for reasons other that financial or medical eligibility (for example, the member dies, moves out of the state, or voluntarily withdraws from the program).
- To initiate a Contractor change when an E/PD member moves into another Contractor's service area in a HCB setting (does not include alternative residential settings.
- To request a PAS reassessment when the case manager thinks the member no longer meets medical eligibility criteria for either the ALTCS or Transitional programs.
- To request a PAS reassessment if a Transitional eligible member has a deterioration of condition and will be/has been admitted to an institutional setting and is expected to stay more than 90 days.
- To request Acute Care Only determination for a member who refuses ALTCS services but who has not signed a Voluntary Withdrawal. Also, change from Acute Care Only back to full LTC when the member accepts services. **MCRs for these situations must be sent to AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit.**
- To request a change in Contract Type when a member has received no LTC services for a full calendar months due to LTC service provider not available or member is temporarily out of the contractor's service area. **MCRs for these situations must be sent to DHCM/ALTCS Unit along with case notes.**
- To inform ALTCS when a member is temporarily out-of-state (>30 days).
- For Maricopa County E/PD members only – to report the member's request to change Program Contractors and the need for an enrollment choice.

NOTE – members who are temporarily out of the Contractor's service area may be provided with LTC services if these are available, in the member's best interests and are approved by the contractor.